DEPARTMENT OF HUMAN SERVICES

FATALITY REVIEW EXECUTIVE SUMMARY

FY 2011

Compiled by
Department of Human Services
Office of Services Review
August 1, 2011

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JULY 1, 2010 – JUNE 30, 2011

Department of Human Services (DHS) Fatality Review Policy requires a review of the deaths of all individuals for whom there is an open DHS case at the time of death or in cases where the individuals or their families have received services through DHS within 12 months preceding the death. Information obtained from case reviews provides insight into systemic strengths and highlights areas in which changes or modifications could enhance systemic response to client needs.

During FY 2011, 164 deaths of current or past DHS clients were reported to the Office of Services Review (OSR). There were eight suicide deaths (5%) and seven homicides (4%). The reviews indicate that abuse and/or neglect were contributing factors in nine (5%) of the 164 deaths. Three (5.6%) of the 53 child fatalities reported by the Division of Child and Family Services (DCFS) died as the direct result of abuse or neglect by their parents/caretakers.

Of the 53 fatalities reported by DCFS, 34 reviews were held (64%), 19 reviews were waived (36%), with no reviews pending. Twenty-seven of the 51 reported DSPD fatalities were reviewed (53%), 24 reviews were waived (47%), with no reviews pending. Two Division of Juvenile Justice Services (DJJS) fatalities were reviewed (100%). On-site reviews were held for five (56%) of the nine reported Utah State Developmental Center (USDC) fatalities with two reviews waived (22%), and two reviews pending (22%). Utah State Hospital (USH) conducted an on-site review for its one reported fatality (100%).

The deaths of 36 individuals who received services through the Division of Aging and Adult Services (DAAS) were reported, with all formal reviews (100%) being waived. The Office of the Public Guardian (OPG) reported the deaths of 23 individuals for whom they provided services. Five of these individuals (22%) were also receiving services through DSPD at the time of their deaths and six individuals (26%) were receiving services through USDC at the time of their deaths. A full committee review was held for one (7.6%) of the 13 individuals receiving services solely through OPG. OPG provided the Fatality Review Coordinator with comprehensive written reports detailing services provided and information relating to the deaths of their 23 clients (100%).

There were 91 (55%) reported deaths of male clients and 73 (45%) reported deaths of female clients. Reported deaths included 18 infants (11%) under the age of one year; 43 individuals (26.2%) between the ages of one to 18 years; 29 individuals (17.7%) between the ages of 19 to 50 years; 57 individuals (34.7%) between the ages of 51 to 80 years; and 17 individuals (10.4%) between the ages of 81 to 97 years.

One DSPD case was referred to the Bureau of Internal Review and Audit (BIRA) and to DSPD administration to review a possible contract violation and/or conflict of interest issue in which contract provider staff were also appointed as an individual's Power of Attorney. This situation is currently under review.

BACKGROUND and METHODOLOGY

In November 1999, the Office of Services Review (OSR) assumed responsibility for reviewing all DHS client fatalities. OSR recognizes the fatality review process as an opportunity to acknowledge good case management, to identify systemic weaknesses, to propose training for Division staff in performance problem areas, to involve Division staff on a local level in the review process, and to make cogent recommendations for systemic improvements. During the 2010 legislative session, the Utah State Legislature passed House Bill 86 by which the DHS fatality review process was codified in statute (62A-16-101).

During FY 2011, the DHS fatality review committees consisted of the Attorney General or designee for the division, a member of management staff (supervisory level or above) from the designated division, and in the case of a child fatality, the Director of the Office of the Guardian ad Litem or designee. DHS Fatality Review Policy indicates that the committees may also include individuals whose expertise or knowledge could significantly contribute to the review process, e.g., a member of law enforcement and/or a physician, medical practitioner, or registered nurse. The Child Fatality Review Committee (CFRC) has been strengthened by the participation of two pediatricians from Primary Children's Medical Center, a representative from the Division of Substance Abuse and Mental Health, and by the Director of the DCFS Professional and Community Development Team. The Director of Professional and Community Development provides a vital link between the committee and DCFS as she and her team develop or strengthen training to address identified problematic patterns of practice.

The DSPD Fatality Review Committee has utilized the knowledge and expertise of two regional DSPD Registered Nurses who have on-going personal contact with many of the DSPD clients and who, in many cases, have first-hand knowledge of a decedent's medical history. The RNs' medical knowledge and insight into health and safety issues is of great value to non-medical committee members. The parent of a disabled child also serves on the committee as a representative of the community.

Notification of client deaths is received through Deceased Client Reports, Certificates of Death, the Office of the State Medical Examiner, newspaper obituaries, emails, etc. The Department of Health provides the Fatality Review Coordinator with Certificates of Death for every child in the State of Utah who dies between the ages of birth and 21 years. These certificates are reviewed against the child welfare database, SAFE, to determine if the child or his family has had services through DCFS within twelve months of the death. If services were provided within this time period, the Coordinator requests and reviews the family's DCFS case file, makes a written summary of the family's history of involvement with the Division, and makes analyses pertaining to case practice and agency culpability.

Prior to the bi-monthly DSPD and CFRC meetings, committee members receive copies of fatality reports to review in preparation for discussion. When deemed appropriate, the committees invite division staff and/or contract providers to committee meetings to provide additional information. Following the committee review, the fatality review reports, with the addition of committee questions, concerns, and/or recommendations, are sent to the DHS Executive Director, the Director of the division under review, and the Director of the region in which the fatality occurred. The Region has fifteen days in which to formulate a reply and, if necessary, a plan of action for carrying out the committee's recommendations. Due to the low number of fatalities in the Division of Juvenile Justice Services, the JJS Committee meets on an as-needed basis.

In FY 2010 the CFRC and the DSPD committee instituted the process of waiving the formal committee review for cases in which there were no practice concerns or in which there was no indication that division practices contributed to the death of the client. The written report for waived cases follows the same format as that for reviewed cases with the addition of the Coordinator's recommendation that the formal review process be waived.

The full report is then reviewed by the chairs of the CFRC and DSPD committees and by the Director of the Office of Services Review. If the chairs and Director concur with the Coordinator's recommendation to waive the formal review, the CFRC and DSPD committee members are provided with the "Findings" and the "Systemic Analyses" of these cases. Committee members can request a full review of any case that has been recommended for a formal review waiver.

Fatality review reports are classified as Private/Protected. The content of the fatality report, i.e., the summary of services to the individual and/or his/her family is classified as "Private". The Fatality Review Committee's analyses of concerns regarding practice and the Committee's recommendations to the Division are classified as "Protected". Requests for copies of fatality reports must meet GRAMA criteria for these classifications.

FINDINGS

The purposes for reviewing a Department of Human Services client death are to assess if the Department had any culpability in that death, to develop means for preventing future client deaths, and to improve Department services to children and adults. The review itself evaluates the system's response to protecting vulnerable clients. Committee members attempt to assess if "best practice" was followed during the provision of services to individuals and families.

During FY 2011, the DHS Fatality Review Committees received reports of the death of 164 individuals who had received services through the Department within twelve months of their deaths. The Committees determined that in all 164 cases (100%), DHS services provided to the clients and/or their families did not contribute to the clients' deaths. Of the 53 reported child fatalities nine deaths (17%) were attributed to abuse or neglect by a parent or caretaker. The following children died as the result of abuse or neglect:

- A child, who was a passenger in a car driven by the parent, died from injuries sustained in a motor vehicle accident. Results of a preliminary drug test conducted on the parent following the accident were positive for cocaine, marijuana, and numerous prescription pain medications.

- A child who had a known seizure disorder and who was to have no unsupervised bathing was left unattended in the bathtub for approximately 10 minutes and was found submerged in the water. It was surmised that the child had a seizure while unattended and drowned. Criminal charges were pending against the child's parent**.**

- In a single-vehicle automobile crash, an unrestrained child was ejected from the car and pinned under the vehicle, which was driven by the parent. Law enforcement reported that the child's parent was intoxicated at the time of the accident.

- A child was left unattended near a fast-running river while the parent and the parent's paramour, who were intoxicated, left the camping area. The child fell into the river and drowned.

- An infant, who was born prematurely and who was supposed to be on oxygen and an apnea monitor, was found dead in its crib. The parent had discontinued use of both the oxygen and the apnea monitor, had taken two prescription anti-anxiety pills, and had slept for 13 hours before checking on the baby. The Medical Examiner stated that the baby's death was suspicious for child abuse or neglect.

- An infant died of complications of shaken baby syndrome. The baby's parent, who inflicted the injuries, was incarcerated on charges of child abuse.

- A child died of blunt force injuries sustained in a motor vehicle accident. The child was not restrained in an age-appropriate safety seat at the time the parent, who was driving the car, hit a deer. The parent had a lengthy history of using illegal drugs, failing to protect the children from domestic violence situations, and failing to ensure that the children were using appropriate safety restraints in their vehicle.

- Two siblings died of asphyxia due to strangulation. County prosecutors charged the children's parent with Aggravated Murder.

DIVISION OF CHILD AND FAMILY SERVICES

SYSTEMIC STRENGTHS

In the majority of cases reviewed the quality of work conducted in Child Protective Services investigations and in providing on-going services to families continued to conform to DCFS Practice Guidelines. In the majority of cases reviewed workers saw the child within priority timeframes, conducted appropriate interviews, collaborated with law enforcement when necessary, worked with service providers to meet the needs of their clients, and if removal was necessary, aggressively sought appropriate kinship or foster placements. Caseworkers appear to be conducting Child and Family Team Meetings, working closely with clients in an attempt to identify client needs and to plan appropriate services, and conducting assessments of a caretaker's capacity to protect. Some examples of good casework include:

- Prior to their child's death a family had been involved with DCFS over a period of three years due to allegations of Domestic Violence related child abuse and Physical Abuse. The parents eventually separated, and a No Contact Order was issued between them, which one parent was unwilling to drop even after both parents had resolved their court cases. The order continued to be a barrier to parental communication that might have facilitated visitation and the divorce process. A clinical worker, assigned as the on-going worker, made excellent use of his clinical skills in working to defuse the parent's anxiety and anger, in helping the parent recognize thinking errors, and in helping the parent process events and options from a more realistic viewpoint. The worker spent countless hours acting as mediator between the grandparent and the parent in an effort to facilitate a very difficult visitation situation. The worker obtained periodic updates form mental health professionals who were working with the parents and with the children. He kept the AAG and the GAL apprised of the parents' progress and of the children's well being and provided the parents with information about and referrals to community resources and services.

- After 25 years of multigenerational involvement with a family, DCFS petitioned the court for Protective Supervision Services (PSS). The on-going worker monitored the family's progress through monthly in-home visits with the parent and the children and through conversations with the other parent who was living out of the home. The worker obtained progress reports from the Probation Officer, the family's therapists, and the drug screening agency and based on these reports, made recommendations to the court regarding placement, visitation, and treatment matters.

  The worker held Child and Family Team Meetings for service and long-range planning and staffed the case with the Assistant Attorney General (AAG). When parental non-compliance issues warranted increased intervention, the worker requested that the AAG file an Order to Show Cause. The worker frequently discussed with the parent the risks that were created for the children when the parents engaged in domestic violence in the children's presence. She also provided the parent with Indian Child Welfare Act (ICWA) information and about the Tribe's right to be involved in legal matters concerning the children. CPS workers in recent years made concerted efforts to contact the children's biological parent.

- In an especially complicated case a team of DCFS workers provided exceptional case management services to the child and family. A parent made an in-person report to a DCFS supervisor that law enforcement was not listening to the parent's allegations of the rape and kidnapping of the parent's child who had been missing for ten days. The DCFS supervisor took immediate action to research the family's history and the history of the alleged perpetrator, to involve law enforcement, the Child Abduction Response Team, and the FBI, and to request a check of NCIC for information regarding the missing youth. Within 11 hours of the parent's report to DCFS the child was located out of state, and the alleged perpetrator was arrested. The CPS worker and the CPS supervisor teamed with law enforcement in accompanying the child back to Utah, in obtaining a medical examination for the child, and in conducting interviews of the child and her sibling at the Children's Justice Center.

  The child's parents voluntarily placed the child in State's custody, and the Permanency worker secured a group home placement for the child. Through a Child and Family Team Meeting the child's team identified service needs, services, visitation issues, and developed a long-term view for the child. From the group home parents and through face-to-face visits with the child the Permanency worker obtained progress reports on the child's behavior, mood, and progress on goals. She obtained periodic reports on the child's mental health needs and progress from the child's therapist and on the child's academic needs and performance from the YIC mentor/teacher. When it became known that the child needed to be in a more protected/supervised school environment, the worker arranged for the child to be moved to a proctor home and to attend a day treatment program.

  The Permanency worker kept law enforcement apprized of additional information she received concerning the alleged perpetrator as it related to the child. She attended court hearings for the perpetrator, fielded complaints and concerns from the ankle-monitoring service, provided information to the child's parents, and obtained a Pick-up Order when the child ran from the child's placement.

SYSTEMIC WEAKNESSES

In FY 2011 formal child fatality reviews were held for 34 of the 53 reported DCFS fatalities. Nineteen formal reviews were waived, as it was deemed by the Director of the Office of Services Review, the Child Fatality Review Committee Chair, and the Fatality Review Coordinator that the cases contained no practice concerns or no indication that Division practices contributed to the deaths of the children. In the reviewed cases the committee noted isolated systemic weaknesses but no pervasive patterns of weakness in case management. Deficits in documentation contributed to questions about corroboration of information, follow-through in providing services, investigation dispositions, and other case-management decisions. Good casework documentation remains a problem for some workers. It is recommended that during FY 2012, DCFS concentrate on improving case practice in the following area:

Documentation

Deficits in documentation were noted in 8 of the 34 cases reviewed (24 %). Some examples of problematic documentation are:

- A worker informed a family that he was going to staff the case with the AAG and that DCFS would be asking the court to order in-home services. He also stated that he would return and discuss the matter once he had staffed the case. Six weeks later the worker

returned to the home and learned that the family had moved four weeks after his first visit. The worker documented that the family had moved to avoid court-ordered services, that they were "running from the Division", and that they were "absconding". However, there is no documentation to indicate that the case had ever been staffed with the AAG or that a petition had ever been filed. The worker did not know if the parents had moved to avoid court-ordered services or if they had other reasons for leaving the trailer park.

The worker's words/phrases of "absconding" and "running from the Division" were inflammatory and possibly inaccurate. Yet future CPS workers who reviewed the family's DCFS history would repeat the idea in their activity logs that the family had absconded to avoid court intervention. It is unknown what influence this supposition had on workers and/or the court when they made future case decisions.

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- A two-year-old child was removed from home as a sibling at risk after the death of the child's infant sibling due to medical neglect. Documentation states that the child was placed in a foster home, that a foster/adoption screening was held, and that the foster parents were willing to take the child. The only other activity log entries were computer generated and gave no information explaining why after five days in foster care the child was court-ordered into the home of the biological parent with whom the child had no discernable relationship. Information in other cases indicated that the parent had been arrested for harassment, that there had been restraining and protective orders against the parent, and that the parent had been incarcerated in the Utah State Prison. This case illustrates the problem of workers pushing policy buttons in SAFE while failing to provide important case information in their activity logs.

- The accuracy and thoroughness of documentation was the primary issue in a case where the worker noted several times in his activity logs that at the request of the parent and stepparent he was unable to interview the alleged victim. However, in the case closure summary the worker stated that he had conducted an initial assessment and complete victim interview with the primary victim "outside the presence of the alleged perpetrator and offered a support person" with the interview taking place "in private and without adults or others present unless law enforcement was present". The worker referred to the child's stepparent as the child's "parent", which made it difficult for a reader to get a clear picture of who was being interviewed and who was reporting which information.

  The closure statement also states that the worker made a "thorough search for and review of any records of past reports of abuse or neglect involving the same child, any sibling, or other child residing in the same household, and the alleged perpetrator . . . ." However, even a cursory review of the family's DCFS history would have given a clear indication that domestic violence had been an on-going problem and that perhaps the current allegations should be thoroughly investigated.

Miscellaneous
The Child Fatality Review Committee identified isolated best-practice weaknesses in several cases, but there was no repetitive pattern of poor casework in the cases reviewed in FY 2011.

DIVISION RESPONSES TO RECOMMENDATIONS

Regions have the responsibility to respond to Committee recommendations, to provide additional information to the Committee when requested, and to explain their rationale for practice decisions. Regions are asked to submit an action plan outlining how they will implement the

Committee's recommendations or to submit a written reply as to why the recommendation(s) cannot be implemented.

In Fiscal Year 2011 DCFS issued a Mandatory Information Communication Practice Alert addressing the following concerns and recommendations made by the Child Fatality Review Committee:

- Intake and CPS workers must make diligent efforts to identify the name of the perpetrator when an "unknown perpetrator" has been assigned to a case by intake. Once the identity of the perpetrator is known, the worker must replace the "unknown perpetrator" with the name of the perpetrator prior to case closure. The worker should also add the date of birth, address, and any other identifying information they have about the perpetrator.

- CPS workers should understand the importance of speaking with as many meaningful collateral contacts as possible who have first-hand knowledge of the physical well-being and safety of a child(ren) named in a report of abuse, neglect, or dependency. Although only one collateral contact is required, workers need to gather as much information as possible from those who have close contact with the children and will aid the worker in making the best safety decision possible.

- CPS workers need to document clearly the reason(s) each allegation is supported or unsupported. Including the definition of the allegation is not sufficient. The allegation section and the case closure statement should include the specific information that indicate why each allegation was either supported or unsupported.

- Intake and CPS workers need to include all children in a household on the CANR, not just the primary victim(s) or other victim (s). They should also include all other known members of the household. Intake and CPS workers need to include as much identifying information as possible for each case person, including dates of birth, phone numbers, addresses etc.

DIVISION OF SERVICES FOR PEOPLE WITH DISABILITIES

COMMUNITY PLACEMENTS

SYSTEMIC STRENGTHS

Support coordinators act as advocates for individuals who are receiving services through the Division and through its contract providers. They are responsible for verifying and providing appropriate documentation necessary to maintain an individual's eligibility for waivered services, provide crisis intervention when necessary, monitor the delivery and appropriateness of contracted services, review monthly provider reports, and assess an individual's well-being through in-person visits in the home and at day program sites.

Contract providers, including day program, group home, and supported living staff, provide daily service to individuals and oversee their physical and emotional safety and well being and made exceptional efforts to provide comfort to individuals suffering from terminal medical conditions. The DSPD Fatality Review Committee recognized the excellent work of several support coordinators and contract provider staff and recommended that they be commended for their outstanding work.

- Day program staff provided "watchful care" for an individual who attended its program for many years. Staff provided the individual with opportunities to choose activities that were of interest to him, to participate in community activities, and to develop positive relationships by encouraging him to interact with others. They also encouraged him to eat healthy snacks to control his blood sugar levels. As the individual's Alzheimer's disease progressed, staff provided additional support to the individual and were especially mindful of his needs. They ensured that the individual was safe at the day program and while out in the community.

- A job coach worked with an individual approximately seven hours a week to help him increase his job skills and to teach him socially appropriate behaviors. While being transported in the job coach's vehicle, the individual experienced a choking incident. The job coach pulled off the road, moved the individual out of the car, and administered the Heimlich maneuver. When the individual did not respond, the job coach called 911 and followed the dispatcher's instructions to attempt to clear the individual's throat and then to begin chest compressions, which he performed until emergency medical personnel arrived. The job coach provided information to law enforcement, notified his supervisor and the individual's residential house manager of the incident, and then went to the hospital where he was informed of the individual's death.

- After an individual was diagnosed with terminal cancer the support coordinator worked closely with his support team to make decisions in the man's best interest. The support coordinator petitioned the Office of the Public Guardian to assume guardianship of the individual in order to assist him with his medical decisions. The support coordinator kept family members informed of the individual's condition and involved the family and provider staff in periodic meetings to discuss problems related to the individual's care. The team formulated workable plans to accommodate family members while respecting the feelings and desires of the host parent. The support coordinator kept the DSPD RN informed of the individual's condition and involved the RN in case staffings.

- In a Self-administered Services (SAS) case the Support Coordinator Liaison and the DSPD Nurse Coordinator provided excellent services to a couple who spoke little or no

- English. The Support Coordinator Liaison arranged for an interpreter when the family was meeting with medical professionals or with government agencies such as the Department of Workforce Services or the Social Security Administration. She communicated frequently with the family through personal visits and telephone conversations and helped them resolve a number of problems connected with Medicaid and Medicare and with the payment of medical providers. She also facilitated a gap payment for medications until Medicare was activated. The Support Coordinator Liaison provided the individual with current information on Utah Independent Living Center outings, information on free physical therapy through Salt Lake Community College, on the free Hand Clinic at the University of Utah, and on applying for food stamps.

  The DSPD Nurse Coordinator met with the individual on a quarterly basis and referred him to classes on dietetics education that were presented in the individual's native language. She spoke with staff at the University of Utah Hospital for updates on the individual's condition and contacted additional staff in an attempt to improve communication between medical professionals and the individual. The RN's efforts resulted in the hospital's ordering a professional service to interpret at medical appointments and to ensure that the individual and his wife were aware of their responsibilities in caring for and managing diabetes.

  The Support Coordinator Liaison and the DSPD Nurse Coordinator advocated for the individual and his wife with medical providers and with pharmacies. The professionals communicated well with one another, which resulted in excellent service to the individual.

- The support coordinator for an individual who had a history of becoming agitated, disruptive, and behaving inappropriately developed a good relationship with the man. She was able to redirect inappropriate conversation and to defuse the individual's agitation. The support coordinator worked with the individual's service team and with his legal guardian to prepare the individual for court hearings. She reviewed the budget and submitted a request for additional services when it became apparent that the individual required increased one-on-one supervision.

  The support coordinator did an excellent job of documenting her case management activities. A typical entry for a face-to-face visit with the individual contained information regarding examination of the individual's medical records to look for a current and accurate diagnosis, a written psychotropic medication plan that detailed medications with their indications and adversities, dosage, and method of administration, as well as contact information for the prescribing clinicians, emergency contacts and procedures for all medical conditions, and verification that medications had been administered and signed off correctly in the med log. She also documented that she questioned house staff about administering medications and about other decisions that needed to be made with regard to seeking medical treatment.

The DSPD RNs continue to provide an excellent resource for Support Coordinators in dealing with the health and safety issues of individuals in service. Many of the individuals receiving services through DSPD and its contract providers are diagnosed with numerous medical and/or behavioral problems for which they receive treatment and prescription medication. Individuals who are immobile are subject to skin breakdown that can lead to serious, and even life-threatening, wounds. RNs visit with individuals in their homes, in hospitals, and in care centers to make assessments of their medical condition and to monitor their progress and their quality of

care. The RNs have knowledge of prescription medications, their uses, the signs of adverse drug interactions and possible side effects. They can monitor the effectiveness and/or appropriateness of these medications and alert medical personnel to potential medication-related problems. In some instances the RNs act as a liaison between medical professionals and providers, family, and DSPD, and they participate with hospital personnel in discharge planning.
The Committee continues to recognize the excellent work of the DSPD RNs in all regions.

In the majority of cases the level of care for individuals appears to have been appropriate and to have been provided as contracted. Individuals were provided with multiple services, excellent medical, dental, and mental health care, and opportunities to participate in meaningful work and community and social activities. Provider staff worked with several individuals in planning and shopping for nutritious meals and in encouraging them to exercise in order to reach or maintain a healthy weight. Respite and supported living services made it possible for 27 individuals (53%) who were eligible for Medicaid services under the Home and Community-based Waiver to remain in their homes and to be cared for by family members or, with minimal support, to live independently.

SYSTEMIC WEAKNESSES
During FY 2011, the DSPD Fatality Review Committee noted some isolated concerns related to the delivery of provider services and to other systemic issues.

Incident Reporting
The Committee noted problems related to incident-report writing in four (8%) of the 51 cases. There were concerns about missing and/or poorly written incident reports, about reports not being sent to the support coordinators within DSPD contractual timeframes, about incident reports not being filled out following the death of an individual, about incident reports being written by someone other than the person who was present at the time of the incident, and about support coordinators not signing incident reports to indicate that they have reviewed the document. Training was recommended for provider staff on writing incident reports with an emphasis on documenting "times", e.g., the time the incident began; the time that emergency procedures were begun; the time that emergency calls were made; the time that emergency staff arrived, etc. Additional training was recommended for support coordinators pertaining to their responsibility to review and sign incident reports and to send incident reports back to the provider if they did not contain adequate information.

Communication of Information
The issue of communication of information between providers and support coordinators and between support coordinators and Administrative Program Managers was noted in three (6%) cases.

- An individual experienced a fall at his day program but the provider did not notify the support coordinator or the individual's guardian about the incident. Even though the support coordinator visited with the individual at the day program the day after the fall, staff did not mention the accident until later in the day in a telephone conversation. The support coordinator requested an Incident Report at that time but did not receive one for an additional two days. Three days after the incident the guardian had not been informed of the fall. In another case an individual was hospitalized, but provider staff did not notify the support coordinator for four days and did not notify the guardian for five days after the individual was admitted to the hospital.

- An individual's case file contained extensive medical provider reports, lab test results, and follow-up information until approximately a year prior to her death. For the following 12 months there were no medical records relating to the time period when the individual had been diagnosed with leukemia, had undergone numerous tests to confirm the diagnosis, and had had frequent blood transfusions. There was also an absence of Incident Reports regarding the individual's failure to take her medications as prescribed, her hospitalizations, and her death. The support coordinator did not communicate on a regular basis with the Administrative Program Manager (APM) and failed to notify the APM of the individual's death until two months after the fact.

- During a support coordinator's face-to-face visit with an individual, group home staff disclosed that the individual had a pressure sore on his upper back that had been "coming and going" for at least three months. When the frustrated support coordinator contacted the program manger for more information, he was told that the individual had been going to the wound clinic for treatment. The support coordinator requested an Incident Report about the situation and stated that he needed updates on the condition of the sore in each monthly progress summary. Most months the support coordinator documented the condition of the back sore as observed during visits, but the provider did not include information about the back sore in any of the following monthly summaries.

DIVISION RESPONSES TO RECOMMENDATIONS

- In response to the Committee's recommendation that a support coordinator be placed on corrective action due to failure to document case management activities in a timely manner, delay in submitting a RAS for critical dental work, lack of follow-up on an Adult Protective Services investigation, and failure to visit or to maintain telephone communication with the individual and his family as required by Medicaid, the contract provider instituted various "tickler forms" that will allow support coordinators an "at-a-glance review" of case activities. The provider also provided training for all their employees on Health and Safety Standards to include RAS and on Scope of Work and Special Conditions to cover visits and communication with individuals and their families.

- An Administrative Program Manager met with private provider administration and staff to review issues related to lack of medical information and activity logs in the case file. Support Coordinator Standards were discussed regarding reporting fatalities, requesting Incident Reports and medical information from the provider, and closing cases in compliance timeframes. The contract provider agreed to set up monthly staffings with its support coordinators to ensure that they are in compliance with the Support Coordinator Standards and has agreed to conduct random audits/reviews of Service Plans, logs, medical information, etc.

The Committee recommended that support coordinators be trained on notifying DSPD RNs about individuals' hospitalizations, acute medical problems, or on-going medical issues and on keeping the RNs fully apprized of any changes in an individual's medical condition. It was also recommended that providers be reminded of their contractual obligation to notify the client's family and/or guardian and DSPD Administration within 24 hours of first knowledge of the death of a person receiving support services.

During FY 2011, the DSPD Fatality Review Committee noted concerns pertaining to the following issues:

Client Case Files
Since the privatization of support coordination services, individual case files are now kept in the offices of various private providers or in the home of support coordinators throughout the state. Contractually, the files are to be kept in a locked space, as they contain confidential and highly-sensitive personal information pertaining to DSPD clients. It is difficult to monitor providers' compliance with this requirement, and it is possible that some case files are not kept in a locked space and that they are open to scrutiny by unauthorized persons.

During FY 2011, a problem arose for the DSPD Fatality Review Coordinator in obtaining the case file of an individual who had died. The support coordinator documented that he had the working file in his possession and that he would keep it until he was asked to release it to the "necessary personnel". The working file was not returned to the DSPD office for two months following the individual's death, and the documents in the working file were five to six years old. The private provider claimed that the primary client case file had been returned to DSPD, and DSPD maintained that they had not received it. The Division gave the provider sufficient time to find the file, but it is still missing. The provider mistakenly believed that DSPD requested the file during an eligibility review prior to the individual's death. However, Division records indicate that an eligibility review for that individual had not been conducted since the support coordinator had come under the supervision of the current Administrative Program Manager. Thus, DSPD had not requested the primary file until after the individual's death.

In response to this problem DSPD Northern Region reported that it has changed the procedure for eligibility reviews and will no longer request that the entire primary file be sent in when documentation is missing in the DSPD file. They will now request that the worker send only the needed documents. Northern Region has implemented a tracking system to monitor all blue case files entering and leaving the Clearfield office. The Region also recommended that a memo or email be sent to all external support coordinators reviewing the time frames for producing files/records when requested by DSPD and informing them that corrective action may take place when these time frames are not met. The Region also sent a corrective action letter to the private provider concerning the maintenance of client case files and for not responding to DSPD requests for records within required time frames.

Auto-fill Visit Discrepancy in Person Centered Service Plan
The DSPD Fatality Review Committee noted that the auto-fill feature in the Person Centered Service Plan pertaining to Division Case Management Services visitation did not correspond with practice guidelines for individuals on the Physical Disabilities Waiver. Unless the DSPD RN's remembered to manually change the template, they were usually not meeting the stated requirements of quarterly in-person visits and monthly family contact.

In response to a concern raised by the Fatality Review Committee and by the Bureau of Internal Review and Audit (BIRA), the Division noted that the quarterly reports from ILC Support Coordinator Liaisons were not documented in the logs in USTEPS but were kept as a hard copy in the consumers' files. Therefore, there was no evidence that the ILC Support Coordinators were making their visits as they were contracted to do.

DSPD administration addressed the concerns and now requires that the DSPD RN's summarize the quarterly reports from the ILC Support Coordinator Liaisons and enter them into the activity logs in USTEPS. These entries demonstrate that the Division has received the quarterly report

and can further demonstrate DSPD's follow-up on issues that arise regarding specific consumers. Currently, USTEPS is not capable of processing scanned documents.

UTAH STATE DEVELOPMENTAL CENTER

During FY 2011, Utah State Developmental Center (USDC) reported the deaths of nine individuals who were or who had been residents of that facility**.** Six of these individuals were also receiving services through the Office of the Public Guardian. Seven individuals died in hospitals, and two individuals died in extended care facilities. Formal death reviews were held at USDC for five individuals, two reviews are pending, and the formal fatality review for two individuals was waived, as these individuals had been in skilled nursing facilities for six or more months prior to their deaths.

"Natural Causes" is certified as the manner of death for each of the nine individuals. Five individuals died of pneumonia, two died of cardiac arrest, one died of conditions incident to cancer, and one died of septic shock due to a perforated bowel. It appears that USDC staff followed practice guidelines and appropriate protocol when handling medical issues. No recommendations for practice improvement were made concerning these fatalities.

DIVISION OF AGING AND ADULT SERVICES

During FY 2011, the Division of Aging and Adult Services reported the deaths of 36 individuals who were receiving or who recently had received services through that agency. Most individuals had been reported as victims of alleged abuse or neglect, and the reports had been investigated by Adult Protective Services (APS). APS investigators conducted thorough investigations into reports of Caretaker Neglect, Self-neglect, Financial Exploitation, and Emotional Abuse/Harm and made dispositions based on information gathered and assessments made. There was no evidence to suggest that DAAS or the APS investigations contributed to the deaths of the 36 individuals.

DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH

UTAH STATE HOSPITAL

During FY 2011, Utah State Hospital reported the death of one individual who was a resident of USH at the time of his death. The Utah State Hospital Clinical Director and the Clinical Risk Manager conducted an on-site Risk Management Fatality Review for this case. The manner of death for the individual was certified as "homicide", and the cause of death was certified as "asphyxia due to strangulation", which was perpetrated by the individual's roommate.

The fatality review committee identified the following strengths related to this case:

- Staff had performed hourly room checks as scheduled;
- Staffing was optimal at the time of the individual's death;
- CPR was initiated quickly;
- The Automated External Defibrillator (AED) was brought to the scene and was used appropriately.
- Hospital administrators met with staff several times during the ensuing week to ensure that staff were all right;
- Social workers met with patients to give them individual therapeutic support;
- The hospital Assistant Director worked well with the decedent's family;

The following weaknesses were identified:

- Staff who called the switchboard to announce the Code Blue was unaware that he/she should then call 911, which caused a short delay in 911 response;
- Some staff expected a different prompt from the AED machine and thought it was not working properly, when, in fact, it was;
- Staff suggested that it would have been helpful to have the following items: a backboard, a cordless telephone in the room, a 15-liter regulator on the oxygen tank, and a more spacious room.

Based on review findings, the fatality review committee made recommendations for improving service and for lessening the level of risk to patients residing at USH, which included:

- Risk Management has included questions on Automated External Defibrillator (AED) and 911 procedure on its quarterly competency quiz, is documenting the results, and will provide additional training to staff as needed;
- Risk Management agreed to provide all units with CODE BLUE calling procedure/visual aids upon approval of hospital executive staff;
- Executive staff began the process of initiating a pilot project to evaluate the use of cordless telephones on several units;
- Risk Management discussed acquiring backboards and determined that backboards would not be utilized, as the removal of the mattress from patient beds was sufficient for CPR efforts.

DIVISION OF JUVENILE JUSTICE SERVICES

The Committee received notification of two Division of Juvenile Justice Services (DJJS) clients who died during FY 2011. One of the decedents had received service through both DJJS and DCFS.

The manner of death for one youth is certified as "Accident" with the cause of death being blunt force injuries sustained in a motor vehicle accident. The youth was living at home, was reporting to a Youth Parole Authority parole officer, was provided with tracking services, and was attending a drug and alcohol treatment group.

The manner of death for the other youth is certified as "Suicide" with the cause of death being blunt force injuries sustained in a jump or fall. The youth was living at home, was attending a day treatment program, and was provided with tracking services evenings and weekends.

SYSTEMIC STRENGTHS
In the cases reviewed by the Fatality Review Committee, youth in DJJS custody received intensive assessments and services that included individual and group therapies, medication management, life skills training, substance abuse counseling and treatment programs, educational services, random drug testing, and tracking. Case managers and trackers were diligent in monitoring the well-being and compliance of their clients.

Excellent case management was done on behalf of a youth and her family prior to and after the youth's death. After hearing of the youth's attempted suicide the case manager immediately went to the hospital and stayed there throughout the night with the parents. The following day the worker left the hospital long enough to complete paperwork associated with the incident and then returned to the hospital to support the parents. When it became apparent that the youth was not going to live, the worker quickly initiated the process to request that the court terminate JJS custody in order for the youth's organs to be donated.

SYSTEMIC WEAKNESSES
The DJJS Fatality Review Committee did not identify any practice concerns or systemic weaknesses in the DJJS cases reviewed.

OFFICE OF THE PUBLIC GUARDIAN

During FY 2011, the Office of the Public Guardian (OPG) reported the deaths of 23 individuals for whom they had provided guardianship services. Six of the 23 individuals were also receiving services through the Utah State Developmental Center, and five individuals were receiving services in community placements through the Division of Services for People with Disabilities. Six individuals were hospitalized, 14 individuals were in rehabilitation/care facilities, and three individuals were in their group/host homes receiving Hospice care at the time of their deaths. The manner of death for 22 of the 23 deaths was certified as "Natural", and the manner of death is "Pending" in one case. Causes of death for the individuals include pneumonia, cardiac arrest, renal failure, cancer, and respiratory failure.

The Director of the Office of the Public Guardian requested a fatality review of the case of one individual who was open with OPG Intake and who was being assessed to determine his eligibility to be appointed a guardian. Initial assessments indicated that the individual did not qualify for guardianship services. Five weeks after the initial assessment the individual's care center doctor reported a significant decline in the man's medical status and in his capacity to make medical decisions. OPG staff failed to share this information with the OPG Intake screening committee or with OPG administration. The individual died without a guardian or someone with Power of Attorney to make and/or consent to appropriate medical treatment.

OPG conducted a thorough investigation into the circumstances surrounding the individual's death and determined that staff had been derelict in failing to report accurate information regarding the individual's medical status, which compromised the Intake screening committee's decision-making process. Staff's employment was terminated according to Department of Human Resources (DHR) policy and procedures.

OPG provided the Fatality Review Coordinator with comprehensive summaries of clients' service histories and with an explanation of the causes of death for the 22 individuals for whom a formal fatality review was waived. It appeared that these individuals received appropriate services and that their deaths were related to age and to medical factors.

DEPARTMENT OF HUMAN SERVICES
FATALITY REPORT
SUMMARY
FY 2011

DEPARTMENT/DIVISION	Number of Reported Deaths	Cases Open at Time of Death	Cases Reviewed	Committee Review Waived	Reviews Pending	Male	Female
DEPARTMENT OF HUMAN SERVICES	**164**	**121**	**69**	**93**	**2**	**91**	**73**
DAAS ***(Division of Aging and Adult Services)***	36	30	0	36	0	18	18
DCFS ***(Division of Child and Family Services)***	53	17	34	19	0	26	27
DJJS *(Division of Juvenile Justice Services)*	1	1	1	0	0	0	1
DJJS/DCFS *(Division of Juvenile Justice Services/ Division of Child and Family Services)*	1	1	0	1	0	1	0
DSPD – COMMUNITIY PLACEMENT ***(Division of Services for People with Disabilities)***	46	45	23	23	0	30	16
OPG *(Office of the Public Guardian)*	12	12	1	11	0	7	5
OPG/DSPD (Office of the Public Guardian/Division of Services for People with Disabilities	5	5	4	1	0	3	2
OPG/USDC *(Office of the Public Guardian/Utah State Developmental Center)*	6	6	2	2	2	2	4
USDC/DSPD (*Utah State Developmental Center/* Division of Services for People with Disabilities*)*	3	3	3	0	0	3	0
USH/DSA/MH ***Utah State Hospital/(Division of Substance Abuse/Mental Health)***	1	1	1	0	0	1	0

CHART I
FIVE-YEAR COMPARISON
FY 2007 – FY 2011

	FY 2007	FY 2008	FY 2009	FY 2010	*FY 2011*
DHS Reported Deaths	133	171	129	159	164
DAAS	3	3	2	34	36
DCFS	49	59	49	38	53
DCFS/DSPD	1	1	3	2	0
DJJS	3	2	3	1	1
DJJS/DCFS	1	2	4	3	1
DSPD	57	75	49	61	46
DSPD/OPG					5
OPG	9	13	7	9	12
USDC	3	4	7	4	3
USDC/OPG	3	2	2	3	6
USH	4	10	4	4	1
Cases Open at Time of Death	101	124	106	111	121
Cases Reviewed	124	139	121	70	69
Abuse & Neglect Deaths	11	22	4	2	9
Accidental Deaths	15	10	12	18	24
Homicides	5	14	5	1	7
Motor Vehicle Accidents	5	9	1	6	9
Suicides	4	5	7	10	8
Undetermined	12	10	9	6	3

CHART II

AGE AT TIME OF DEATH

FY 2011

AGE IN YEARS	DHS	DAAS	DCFS	DJJS	DJJS/ DCFS	DSPD	DSPD/ OPG	OPG	USDC	USDC/ OPG	USH
< 1	18		18								
1 – 3	7		7								
4- 6	4		4								
7- 10	7		7								
11 - 14	11		7			4					
15 - 18	14		10	1		3					
19 - 30	10				1	8					1
31 – 50	19	2				13	1	1		2	
51- 65	35	6				14	4	5	3	3	
66 – 80	22	14				4		3	`	1	
81 - 90	10	7						3			
91 – 97	7	7									
TOTALS	164	36	53	1	1	46	5	12	3	6	1

CHART III

ACCIDENTAL DEATHS

CAUSE OF DEATH	DHS	GENDER	AGE	DIVISION
Asphyxia	5			
Choking		Female	6 months	DCFS
Positional		Female	5 months	DCFS
		Female	6 months	DCFS
Wedging		Female	7 months	DCFS
Improperly placed endo-tracheal tube		Female	22	DSPD
Auto/Pedestrian Accident	2			
		Female	11	DCFS
		Female	13	DCFS
Dropped by Parent	1			
		Male	2 months	DCFS
Drowning/Near Drowning	3			
		Male	2	DCFS
		Male	10	DCFS
		Male	13	DCFS
Head Injury & Complications	1			
		Male	34	DSPD
Hypothermia	1			
		Male	74	DAAS
Motor Vehicle Accident	9			
		Female	3	DCFS
		Male	3	DCFS
		Male	4	DCFS
		Female	4	DCFS
		Female	5	DCFS
		Male	6	DCFS
		Female	16	DCFS
		Male	17	DJJS/DCFS
		Male	18	DCFS
Smoke Inhalation/Thermal Injuries	2			
		Female	5	DCFS
		Male	6	DCFS
TOTAL	24			

CHART IV
HOMICIDE DEATHS
FY 2011

MANNER OF HOMICIDE	DHS	GENDER	AGE	DIVISION
Gunshot	3			
		Male	14	DCFS
		Female	13	DCFS
		Male	35	DSPD
Shaking	1	Male	11 months	DCFS
Strangulation	3			
		Male	8	DCFS
		Female	7	DCFS
		Male	28	USH
TOTAL	7			

CHART V
SUICIDE DEATHS
FY 2011

MANNER OF SUICIDE	*DHS*	*GENDER*	*AGE*	DIVISION
Asphyxia (Hanging)	4			
		Male	13	DCFS
		Male	14	DCFS
		Female	16	DCFS
		Female	18	DCFS
Gunshot Wound	3			
		Female	16	DCFS
		Male	17	DCFS
		Male	18	DCFS
Fall/Jump	1			
		Female	17	DJJS
TOTAL	8			

CHART VI
ABUSE/NEGLECT DEATHS
FY 2011

CAUSE OF DEATH	DHS	GENDER	AGE	DIVISION
Motor Vehicle Accident	3			
		Male	2	DCFS
		Female	3	DCFS
		Male	4	DCFS
Drowning	2			
		Male	2	DCFS
		Male	10	DCFS
Medical Neglect	1			
		Female	7 months	DCFS
Physical Abuse	3			
		Male	11 months	DCFS
		Female	7	DCFS
		Male	8	DCFS
TOTAL	9			

CHART VII
MEDICAL EXAMINER'S DETERMINATION
MANNER OF DEATH
FY 2011

MANNER OF DEATH	DHS	DAAS	DCFS	DJJS	DSPD	DSPD/ OPG	OPG	USDC	USDC/ OPG	USH
Accident	24	1	20	1	2					
Homicide	7		5		1					1
Natural Causes	119	34	19		41	4	12	3	6	0
Pending	3	1			1	1				
Suicide	8		7	1						
Undetermined	3		2		1					
TOTALS	164	36	53	2	46	5	12	3	6	1

CHART VIII
DECEDENTS' RACE
FY 2011

RACE	DHS	DAAS	DCFS	DCFS/ DJJS	DJJS	DSPD	DSPD/ OPG	OPG	USDC	USDC/ OPG	USH
AMERICAN INDIAN											
Goshute	1					1					
Navajo	1						1				
ASIAN	1		1								
BLACK/AFRICAN AMERICAN	4		2			1					1
CAUCASIAN	136	36	39		1	37	4	10	3	6	
HISPANIC	18		10	1		5		2			
PACIFIC ISLANDER											
Samoan	1		1								
Tongan	2					2					
TOTALS	164	36	53	1	1	46	5	12	3	6	1

CHART IX
FATALITIES BY REGION AND OFFICE
FY 2011

DIVISION OF AGING AND ADULT SERVICES

REGION	TOTAL	OFFICE	TOTAL
Central	20		
		Salt Lake City	20
Northern	5		
		Logan	3
		Ogden	2
Southern	11		
		Blanding	1
		Cedar City	3
		Price	3
		Provo	2
		St. George	2
TOTAL	36		36

DIVISION OF CHILD AND FAMILY SERVICES

REGION	TOTAL	OFFICE	TOTAL
Eastern	4		
		Price	2
		Roosevelt	1
		Vernal	1
Northern	15		
		Bountiful	2
		Brigham City	2
		Clearfield	3
		Logan	1
		Ogden	7
Salt Lake Valley	19		
		Magna	1
		Metro	4
		Mid Towne	4
		Oquirrh Neighborhood	4
		Salt Lake Regional Support	1
		South Towne	4
		Tooele	1
Southwest	5		
		Cedar City	1
		Manti	2
		Richfield	1
		St. George	1
Western	10		
		American Fork	2
		Heber City	1
		Provo	6
		Spanish Fork	1
TOTAL	53		53

CHART IX (Continued)
FATALITIES BY REGION AND OFFICE

DIVISION OF JUVENILE JUSTICE SERVICES

REGION	TOTAL	OFFICE	TOTAL
Region I	2		
		Ogden	2
TOTAL	2		2

DIVISION OF SERVICES FOR PEOPLE WITH DISABILITIES

COMMUNITY BASED and
UTAH STATE DEVELOPMENTAL CENTER (USDC)

REGION	TOTAL	OFFICE	TOTAL
Central	27		
		Administration	5
		Metro	22
Northern	14		
		Clearfield	9
		Logan	4
		Ogden	1
Southern	10		
		Price	2
		Provo	3
		St. George	5
USDC	3		
		American Fork	3
TOTAL	54		54

OFFICE OF THE PUBLIC GUARDIAN

DIVISION	TOTAL	OFFICE	TOTAL
OPG	12		
		Salt Lake/Administration	12
DSPD/OPG	5		
		Clearfield	1
		Metro	2
		Provo	1
		St. George	1
USDC/OPG	6		
		American Fork	6
TOTAL	23		23

FATALITIES BY REGION AND OFFICE
CHART IX (Continued)

DIVISION OF SUBSTANCE ABUSE/MENTAL HEALTH
UTAH STATE HOSPITAL

REGION	TOTAL	OFFICE	TOTAL
USH	1		
		Provo	1
TOTAL	1		1